



Medicare & Health Insurance Claims

**Simple Step-by-Step Directions for
Hospital & Medical Bills**

Claims Filing & Your Responsibilities

Claims filing is a vital part of having health insurance. Make sure that you:

- Know your responsibilities;
- Understand the language, the paperwork and the processing; and
- Keep track of all of your bills and contacts with your health care providers and Medicare (such as telephone calls, faxes, letters, e-mails, etc.).

All Medicare providers are required by law to submit your Medicare claims. A Medicare provider is someone who provides medical and health services or supplies such as a:

- Clinical Psychologist
- Home Health Agency
- Licensed Clinical Social Worker
- Occupational Therapist
- Physical Therapist
- Doctor
- Hospital
- Medical Supply Company
- Pharmacy
- X-ray Company

Although the Medicare provider files your claims, it is **your** responsibility to give them correct information so that the processing of your claim will be as error-free as possible.

Your Responsibilities

1. Do not confuse your Medicare number with your Social Security number. Your Medicare number has a letter at the end.
2. Always take your Medicare card with you when you visit your doctor or other health care provider. The provider will photocopy your Medicare card and keep the photocopy as a part of your medical records.
3. Always give the provider correct information. Incorrect information may cause a delay in processing your claim, or it may cause payment of your claim to be denied.
4. Check with each of your doctors and other health care providers to make sure that they have recorded your Medicare number correctly.
5. Always give the provider your name **exactly** as it is shown on your Medicare card. Notify the Social Security Administration by calling **toll-free 1-800-772-1213** if your name changes, or if you damage or lose your Medicare card.
6. Be sure the provider has your current address and telephone number in case Medicare needs to contact you for additional information about your claim.

7. Tell the provider if your injury or illness is the result of:

- A work-related incident (for worker's compensation purposes);
- An automobile accident (for automobile insurance purposes); or
- An injury that might result in a liability claim against a homeowner (for homeowner's insurance purposes.)

Federal law requires that claims include this information. In the cases shown above, your claim will be sent to the other insurance company first, and then to Medicare.

8. Tell your doctor or other provider if you have additional insurance, such as:

- Insurance through your employment;
- Medicare supplement (Medigap) insurance;
- Medicaid; or
- Veterans Administration-related health care coverage.

The provider will photocopy this insurance card and keep the photocopy as a part of your medical records. Ask the provider if they will file your secondary or supplemental insurance claims for you. If they will not, you will need to file them yourself.

9. Tell your doctor or provider if you are over age 65 and continuing to work. If you have health insurance through your work, it may be considered to be your primary insurance rather than Medicare.

10. Federal law authorizes Medicare to ask for medical information needed to:

- Confirm your identity;
- Determine your Medicare eligibility;
- Determine your coverage; or
- Ensure that proper payment is made.

This information may be shared with others who are involved with the processing of your claim. You may refuse to supply requested information except when it relates to:

- Work injuries;
- Automobile injuries; or
- Other liability-related insurance claims.

Withholding requested information may result in delayed payment or denial of payment for your claim.

Understand These Words

Understanding the terms used by Medicare and other health insurance claims processors will make you feel more comfortable when discussing the status of your claim. Try to become familiar with the following words:

Assignment - An agreement between Medicare, a doctor or other health care provider or supplier, and you, the beneficiary. It means that the provider will accept the amount that Medicare approves as payment in full. If a provider does not “accept assignment”, they will not accept Medicare’s approved amount as payment in full. A provider cannot, however, charge whatever he or she chooses to you, a Medicare beneficiary. The amount (called the “limiting charge”) that a provider can bill you will be indicated on your Medicare Summary Notice (MSN). The maximum limit is 15% over Medicare’s approved amount, and applies only to certain services, not to supplies or equipment.

Beneficiary - Any person who receives benefits. A Medicare beneficiary is anyone who is entitled to have their medical bills paid by Medicare.

Carrier - A private insurance company that has a contract with the federal government to handle claims from doctors and suppliers of services covered by Medicare Part B Medical Insurance.

Claim - A bill requesting that medical services be paid by Medicare or by some other insurance company.

Co-Payment - A specified dollar amount or percentage of covered expenses (called “coinsurance”) which you must pay toward medical bills. [Examples: Medicare Part A Hospital Insurance requires that you pay a co-payment for days 61-90 that you stay in a hospital. Medicare Part B requires that you pay a co-payment of 20% of the approved amount for physician services.]

Deductible - The amount of money which you must pay before Medicare or other insurance payments begin.

Denial - A decision by Medicare or other insurance companies that your claim for benefits will not be approved and paid. Common reasons for denial include that the service received was not:

- Approved;
- Considered “medically necessary”;
- A covered service;
- Provided in an appropriate setting; or
- Provided by an approved participating provider.

DMERC - Durable Medical Equipment Regional Carrier. While other Medicare Part B claims are filed with your local carrier, durable medical equipment, prosthetics, orthotics and medical supplies claims are sent to the DMERC.

EOB - An Explanation Of Benefits describes what benefits were paid (or not paid) by your Medicare supplemental insurance (Medigap) or other private health insurance company.

Intermediary - A private insurance company that has a contract with the federal government to process claims from hospitals, skilled nursing facilities, home health agencies and hospices. These groups make claims for services covered by Medicare Part A.

Limiting Charge - The maximum amount that a non-participating physician is permitted to charge for a service on a nonassigned claim. The amount the physician can charge for the service will be noted on the Medicare Summary Notice (MSN) statement from Medicare.

MSN - A “Medicare Summary Notice” is sent to you by the intermediary or carrier that processed your claim. The MSN is not a bill. See Page 8 of this book for a sample MSN.

Participating Physician - A doctor who signs a participation agreement, thereby agreeing to accept Medicare’s approved amount for a service as payment in full.

Provider - Someone who provides health care services or supplies such as a:

- Clinical Psychologist
- Doctor or Hospital
- Medical Supply Company
- Home Health Agency
- Pharmacy
- Physical Therapist
- Licensed Clinical Social Worker
- Occupational Therapist
- X-ray Company

Primary Insurance or First Payer - The insurance which has primary responsibility for your health care claims, and are billed first. For most people 65 and older, Medicare is their first payer.

Secondary Insurance or Second Payer - When you have more than one type of insurance, the secondary insurance pays only after the first payer has done so. For many people 65 and older, a Medicare supplement policy or retiree health plan from a former employer is their second payer.

Skilled Nursing Care - Care which can only be provided by, or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility (SNF) - A Medicare-approved facility that is staffed and equipped to give skilled nursing care, skilled rehabilitation services and other related health services for which Medicare pays benefits.

Steps for Medicare Part A Claims

The following are the processing steps for claims for services received from a hospital, skilled nursing facility, home health care agency or hospice:

1. The hospital, skilled nursing facility, home health agency or hospice (hereafter referred to as “The facility”) sends your claim to Medicare Part A.

You may receive monthly bills or statements from the facility before they are paid by Medicare or other insurance. When possible, wait until insurance has paid the facility before you pay them. However, to avoid problems, tell the facility that you intend to wait until your insurance has paid them before you pay the rest of your bill.

2. Medicare Part A pays the facility directly. Medicare Part A sends an “Medicare Summary Notice” (MSN) to you so that you know that the facility has been paid.
3. A Medicare supplement (Medigap) policy usually pays the Medicare Part A deductible and co-payments. Other plans may pay part or all of the Medicare Part A deductible and co-payments.
4. For the portion of your bill that Medicare does not pay, ask the facility’s billing department which of the following options apply:
 - A. The facility mails the claim directly to your Medigap or secondary insurance company; or
 - B. You mail the following documents to your Medigap or secondary insurance company:
 - A copy of the Medicare Summary Notice;
 - A copy of the itemized bill from the facility (if required); and
 - A completed claim form (if required).

Remember: Keep your original forms and make photocopies to mail.

Your insurer may require one or more of the three forms shown above. Determine the insurer’s claim requirements by calling the telephone number listed on your insurance card.

5. Either your Medigap or secondary insurance will pay the facility directly, or they will send you the payment and you will need to send it to the facility.
6. You pay the facility for any services that Medicare and your supplemental insurance did not cover.

Steps for Medicare Part B Assigned Claims

The following are the processing steps for claims for services received from a doctor who participates with Medicare:

1. The doctor's office sends your claim to the Medicare Part B carrier.
2. Medicare Part B sends you a MSN and pays **the doctor** 80% of the amount approved by Medicare if you have already met your Part B deductible.
3. Ask your doctor's billing department which one of the following options applies:
 - A. Medicare Part B mails the claim directly to your Medicare supplement (Medigap) insurer. Your Medigap insurer pays the doctor the remaining 20% balance;
 - B. Your doctor's office mails the claim directly to your Medigap or secondary insurance; or
 - C. You mail the following documents to your Medigap or secondary insurer:
 - A copy of the MSN;
 - A copy of the itemized doctor's bill (if required); and
 - A completed claim form (if required).

Be sure to keep your original forms and make photocopies to mail.

4. Your insurer sends you a MSN and pays you (except in option 3A.)

A Medigap policy usually pays 20% of Medicare's approved amount if you have met your Medigap deductible. Secondary insurance may pay all or part of the 20% of the bill not paid by Medicare.

5. You pay the doctor the remaining 20% of Medicare's approved amount (except in option 3A.)

Steps for Medicare Part B Unassigned Claims

The following are the processing steps for claims for services received from a doctor who **DOES NOT** participate with Medicare:

1. The doctor's office sends your claim to the Medicare Part B carrier.
2. Medicare Part B sends you a MSN and **pays you** 80% of the amount approved by Medicare, if you have already met your Part B deductible.

Important: A check from Medicare will be attached to the lower part of the MSN. Since it does not look like a typical check, many people do not realize that this is their payment. If you have not already paid the doctor or other health care provider, use the check attached to the MSN to pay them.

3. Ask your doctor's billing department which one of the following options applies:
 - A. Your doctor's office mails the claim directly to your Medigap or secondary insurance; or
 - B. You mail the following documents to your Medigap or secondary insurer:
 - A copy of the MSN;
 - A copy of the itemized doctor's bill (if required); and
 - A completed claim form (if required).

Be sure to keep your original forms and make photocopies to mail.

4. Your insurer sends you an Explanation Of Benefits (EOB) and pays you.

A Medigap policy usually pays 20% of Medicare's approved amount if you have met your deductible. A secondary insurance may pay all or part of the 20% of the bill not paid by Medicare.

5. You pay the doctor the remainder of the bill.

Note: Doctors who do not accept Medicare assignment DO NOT accept Medicare's approved amount as "payment in full". They expect to be paid the amount that they charge, which is usually higher than the amount approved by Medicare.

However, they are NOT permitted to charge you more than a certain percentage above Medicare's approved amount for most services - called a "limiting charge". Your Medicare Summary Notice (MSN) will indicate the amount for which the doctor can legally bill you.

SAMPLE

Medicare Summary Notice

1

June 16, 2002

4

Beneficiary Name
Street Address
City, State ZIP Code

5

HELP STOP FRAUD: Protect your Medicare Number as you would a credit card number.

CUSTOMER SERVICE INFORMATION

2

3 **Your Medicare Number: 111-11-111A**

If you have questions, write or call:

Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Phone Number: (XXX) XXX-XXXX

1-800-XXX-XXXX

TTY for Hearing Impaired: 1-800-XXX-XXXX

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This is a summary of claims processed from 5/15/02 through 6/15/02.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 12345-84956-84556		8				14
Doctor name, Street Address, City, State, ZIP Code		15	10	11	12	13
		\$55.00	\$44.35	\$0.00	\$44.35	a
03/07/02 1 Office/Outpatient Visit, ES (99214)						b
7	9					

THIS IS NOT A BILL - Keep this notice for your records.

Notes Section:

- a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.
b This approved amount has been applied toward your deductible.

Deductible Information:

17

You have now met \$44.35 of your \$100 Part B deductible for 2002.

General Information:

18

Please notify us if your address has changed or is incorrect as shown on this notice.

Appeals Information - Part B

19

If you disagree with any claims decision on this notice, you can request an appeal by December 16, 2002.

Follow the instructions below:


- 1) Circle the item(s) you disagree with and explain why you disagree.
- 2) Send this notice, or a copy, to the address in the "Customer Service Information" on Page 1.

3) Sign here _____ Phone Number (____) _____

How to Read Your Medicare Summary Notice (MSN)

The descriptions shown below correspond with the numbered items on the sample MSN shown on the previous page.

1. The **Date** the MSN was sent.
2. The **Customer Service Information** box. Write or call using the information in this box if you have questions about your MSN. For all inquiries, include your Medicare number, the date of the notice, and the specific date of service you have questions about.
3. Your **Medicare Number**. It should match the number on your Medicare card.
4. Your **Name and Address**. If these are incorrect on your MSN, please contact both the company shown in the customer service information section and the Social Security Administration immediately.
5. Read the **Help Stop Fraud** message for information on ways to protect yourself and Medicare against fraud and abuse.
6. **Part B Medical Insurance - Assigned Claims/Unassigned Claims**. This line describes the category of services received. It tells you if the claim is for a Medicare Part A or Part B service or for durable medical equipment. See the back of your MSN for an explanation of Medicare assignment.
7. **Dates of Service**. This shows when your doctor or supplier provided the service(s) listed on the MSN. Compare these dates with the dates shown on the bill from your doctor or supplier.
8. Each claim is assigned a **Claim Number**, which you may be asked to provide when calling about your MSN.
9. **Services Provided** is a brief description of the service or supply, the number of services and the supply code.
10. **Amount charged** is the charge submitted to Medicare by the provider of the service(s).
11. **Medicare Approved** is the amount Medicare approved for the service(s) you received.

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12. **Medicare Paid Provider.** In most situations, Medicare pays 80% of the approved amount after subtracting any unmet portion of the yearly deductible. For unassigned service(s), this column is titled “Medicare Paid You”.
 13. **You May Be Billed.** This is the total amount the provider is allowed to bill you. It combines the deductibles, the coinsurance and any non-covered charges. If you have supplemental insurance, it may pay all or part of this amount.
 14. **See Notes Section.** If a letter appears in this column, refer to the Notes Section of the MSN.
 15. **Provider’s Name and Address.** More than one name may appear in this area. If you were treated by a clinic or group medical practice, the clinic or group name will be shown, followed by the name of the doctor who performed the service. If the service was ordered or referred by another doctor, the referring doctor’s name may also be listed. The address shown is the billing address which may be different from where you received the service(s).
 16. The **Notes Section** gives more detailed information about your claim.
 17. The **Deductible Information** section shows how much of your Medicare yearly deductible has been met.
 18. The **General Information** section provides important Medicare news and information.
 19. **Appeals Information**, such as how and when to request an appeal, is shown here. See the back of your MSN for more information on appeals and how to get help with appeal requests.

Keep A Record

Medical bills, MSNs and EOBs can result in a puzzling pile of paperwork. The process of organizing, submitting and keeping track of hospital and medical bills can seem overwhelming, especially to someone who has never done it before.

Organization is the key to maintaining control. The Virginia Department for the Aging has designed the “Insurance Claims Record” to help you organize information about your medical bills. Use it (or a similar form) to help you manage your health insurance paperwork. A copy of the form has been included with this book.

Photocopy the form before completing it so that you will have blank copies on hand for use in the future. You may also contact the Virginia Department for the Aging to obtain additional copies of the form. Contact information for the Virginia Department for the Aging can be found on Page 14 or the back cover of this book.

The Insurance Claims Record form

Your “Insurance Claims Record” is a yearly account of your health care. For each service you receive, write down information such as:

- The date you received the service(s);
- The service provider’s name;
- The service(s) you received;
- The cost of the service(s);
- The amount(s) that Medicare pays for the service(s);
- The amount(s) that your secondary insurance or other insurance pays for the service(s);
- How much applies to your deductible; and
- The amount you need to pay.

If used faithfully, the “Insurance Claims Record” can show progress made in processing a claim, and the next step you should take, if any.

You will have the reward of knowing that both Medicare and your secondary insurance have *paid the costs for which they are responsible*.

You will also have the satisfaction of knowing that you are paying *only the costs for which you are responsible*.

Steps For Using The Insurance Claims Record

1. Always use a pencil when writing on the form.
2. Use a separate Insurance Claims Record form for each family member.
3. Start a new form at the beginning of each year.
4. Arrange your bills and Medicare Summary Notices (MSNs) by the **Dates of Service**, item number 7 on the sample MSN on Page 8 of this book.
5. Staple together the bill(s) and the MSN for each particular service/date.
6. Record each service on the Insurance Claims Record by the date of service. Start with January and continue month by month. Number the bills to correspond with the line number on the Insurance Claims Record.
7. Request missing MSNs from one of the following sources, depending on the type of service you received:

Part A Hospital Claims: Request MSNs for outpatient or inpatient hospital services from the Part A intermediary (see Page 13 of this book).

Part B Medical Claims: Request Part B MSNs from your Part B Carrier (see Page 13 of this book).

8. If necessary, mail claims to your Medigap or secondary insurer. Include the following documents:

- A copy of the MSN;
- A copy of the itemized doctor's bill (if required); and
- A completed claim form (if required).

Be sure to keep your original forms and make photocopies to mail.

9. Use the "Remarks" column of the Insurance Claims Record for special comments. Some examples are shown below:

"\$X (amount) applied to Medicare deductible on X/XX/XX (date)."

"Called carrier and requested MSN on XX/XX/XX (date)."

Resources

Medicare Part A

If you have Medicare Part A questions or concerns, contact:

United Government Services
Medicare Part A
P.O. Box 12201
Roanoke, VA 24023-2201

Toll-Free: 1-877-768-5471
Roanoke area: (540) 985-3931

Medicare Part B

If you have Medicare Part B questions or concerns, contact one of the following offices according to where you live (except for railroad retirees, who have their own contact number, also shown below):

Residents of Arlington County, Fairfax County and the cities of Alexandria, Falls Church and Fairfax:

Trailblazer Health Enterprises, Inc.
Timonium II
1954 Greenspring Drive, Suite 600
Timonium, MD 21093

Toll-Free: 1-800-444-4606
Hours of operation: 8:30 a.m. to 4:30 p.m.
Eastern Standard Time (EST) on business days

Residents of the rest of the state of Virginia should contact:

Trailblazer Health Enterprises, Inc.
P.O. Box 26463
Richmond, VA 23261-6463

Toll-Free: 1-800-552-3423
Hours of operation: 8:00 a.m. to 4:00 p.m.
Eastern Standard Time (EST) on business days

Railroad retirees should contact:

Railroad Medicare
P.O. Box 10066
Augusta, GA 30999-0001

Toll-Free: 1-800-833-4455
Hours of operation: 9:00 a.m. to 5:15 p.m.
Eastern Standard Time (EST) on business days

TriCare For Life

PGBA/TriCare - Region 2/5
TriCare for Life
P.O. Box 7052
Camden, SC 29020-7052

Toll-Free: 1-800-932-9501
Hours of operation: 6:00 a.m. to 9:00 p.m.
Eastern Standard Time (EST)

Durable Medical Equipment, Prosthetics, Orthotics & Medical Supplies

If you have questions concerning durable medical equipment, prosthetics, orthotics or medical supplies, contact the Durable Medical Equipment Regional Carrier (DMERC), as follows:

DMERC
Adminastar Federal, Inc.
P.O. Box 240
Indianapolis, IN 46206-0240

Toll-Free: 1-800-270-2313

Social Security Administration

For a detailed explanation of Medicare claims, refer to the most current edition of the “Medicare & You” handbook (publication number 10050). To get a free copy, contact:

Your local Social Security Administration Office - you can find their telephone number listed in the “government blue pages” of your telephone directory, or call the Social Security Administration **toll-free at 1-800-772-1213**.

Virginia Insurance Counseling & Assistance Program (VICAP)

The Virginia Insurance Counseling and Assistance Program (VICAP) is a free insurance counseling program funded by the Centers for Medicare and Medicaid Services (CMS). VICAP helps beneficiaries, their families and caregivers understand Medicare, Medicaid and medical bills. VICAP also provides assistance with decisions about Medicare supplement (Medigap) insurance and long-term care insurance.

To find the VICAP program nearest you, contact your local **Area Agency on Aging**. You can find their telephone number in your local telephone directory.

You can also contact the Center for Elder Rights at the Virginia Department for the Aging, as shown below:

Center for Elder Rights
Virginia Department for the Aging
1600 Forest Avenue, Suite 102
Richmond, VA 23229
E-mail: aging@vdh.state.va.us

Toll-Free: 1-800-552-3402
Nationwide (Voice/TTY)
Richmond area: (804) 662-9333
Fax: (804) 662-9354
Web Site: www.aging.state.va.us



The Center for Elder Rights
Virginia Department for the Aging
1600 Forest Avenue, Suite 102
Richmond, VA 23229
Toll-Free: 1-800-552-3402
Nationwide (Voice/TTY)
Phone: (804) 662-9333
Fax: (804) 662-9354
E-mail: aging@vdh.state.va.us
Web Site: www.aging.state.va.us

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